Nominal group technique: a highly structured group process that provides an orderly procedure for obtaining qualitative information from specific groups who are closely associated with the area of interest.

Intention to treat analysis (ITT): all patients are analysed in the groups to which they were randomised, even if they failed to complete the intervention or received the wrong intervention.

Grounded theory: an approach to inquiry that focuses on the culture or subculture of a group of people, with an effort to understand the world view of those under study.

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Data saturation (saturation, redundancy): a process of collecting data in a qualitative research study to the point where no new themes are generated.

Ethnography (ethnographic study): an approach to inquiry that focuses on the culture or subculture of a group of people, with an effort to understand the world view of those under study.

Ethnomethodology: an approach to inquiry that focuses on the way people make sense of their everyday lives.

Blinding (masking): in an experimental study, refers to whether patients, clinicians providing an intervention, people assessing outcomes, and/or data analysts were aware or unaware of the group to which patients were assigned. In the design section of Evidence-Based Nursing abstracts of treatment studies, the study is identified as blinded, with specification of who was blinded; unblinded, if all parties were aware of patients’ group assignments; or blinded (unclear) if the authors did not report or provide us with an indication of who was aware or unaware of patients’ group assignments.

Concealment of randomisation: concealment of randomisation is specified in the design section of Evidence-Based Nursing abstracts of treatment studies as follows: allocation concealed (deemed to have taken adequate measures to conceal allocation to study group assignments from those responsible for assessing patients for entry in the trial [ie, central randomisation; sequentially numbered, opaque, sealed envelopes; sealed envelopes from a closed bag; numbered or coded bottles or containers; drugs prepared by the pharmacy; or other descriptions that contain elements convincing of concealment]); allocation not concealed (deemed to have not taken adequate measures to conceal allocation to study group assignments from those responsible for assessing patients for entry in the trial [ie, no concealment procedure was undertaken, sealed envelopes that were not opaque or were not sequentially numbered, or other descriptions that contained elements not convincing of concealment]); unclear allocation concealment (the authors did not report or provide a description of an allocation concealment approach that allowed for the classification as concealed or not concealed).

Confidence interval (CI): quantifies the uncertainty in measurement; usually reported as 95% CI, which is the range of values within which we can be 95% sure that the true value for the whole population lies.

Conversation analysis: examines the organization and structure of conversation, including all that is said.

Crossover trial: a method of comparing 2 interventions in which patients are switched to the alternative intervention after a specified period of time.

Receiver operating characteristic (ROC) curve: an analysis used to assess the clinical usefulness of a diagnostic or screening test. It yields a score that has the highest rates of both sensitivity and specificity with respect to a diagnosis – that is, a score that will give the maximum rate of accurate classifications.

Standardised mean difference: in a systematic review, a way of combining the results of studies that may have measured the outcome (eg, pain) in different ways, using different scales; effects are expressed as a standard value, with no units (difference between 2 means / estimate of within group standard deviation).

Weighted mean difference: in a meta-analysis, used to combine outcomes measured on continuous scales (eg, height), assuming that all trials measured the outcome on the same scale; the mean, standard deviation and sample size of each group are known, and weight given to each trial is determined by the precision of its estimate of effect.

Number needed to harm (NNH): number of patients who, if they received the experimental treatment, would lead to 1 additional person being harmed compared with patients who receive the control treatment; this is calculated as 1 / absolute risk increase (rounded to the next whole number), accompanied by the 95% confidence interval.

Number needed to treat (NNT): number of patients who need to be treated to prevent 1 additional negative event (or to promote 1 additional positive event); this is calculated as 1 / absolute risk reduction (rounded to the next whole number), accompanied by the 95% confidence interval.

Power: the ability of a study to detect an actual effect or difference between groups; it has to do with the adequacy of sample size. Before a study begins, researchers often calculate the number of participants required to detect a difference between 2 groups. If a study has insufficient power (ie, sample size is too small), actual differences between groups may not be detected.

Relative benefit increase (RBI): the proportional increase in the rates of good events between experimental and control participants; it is reported as a percentage (%).

Relative risk (RR) (risk ratio): proportion of patients experiencing an outcome in the treated (or exposed) group divided by the proportion experiencing the outcome in the control (or unexposed) group.

Relative risk increase (IRI): the proportional increase in bad outcomes between experimental and control participants; it is reported as a percentage (%).

Relative risk reduction (RRR): the proportional reduction in bad outcomes between experimental and control participants; it is reported as a percentage (%).